

Meeting Notes

1. Introductions by participants:

Members

- Ed Barthell, Chair
- Janice Hand
- Dana Richardson
- Gary Bezucha

Resources

- Kathy Blair
- Debbie Siegenthaler
- Kathi Steele
- Arthur Wendall

Staff

- Alison Bergum
- Seth Foldy
- Stacia Jankowski
- Larry Hanrahan
- Susan Wood

2. Members reviewed the minutes from the May 16 meeting. Ed Barthell asked for the inclusion of “increased use of electronic health records” as the fourth workgroup referenced under the bullet addressing the American Health Information Community on page 3, the deletion of repetitive language in the item addressing the Digital Health Conference on page 3, and the correction of a typo on page 4. The minutes were approved with these amendments.
3. Seth Foldy provided the document titled “Governor Doyle’s eHealth Initiative: Assessing Stakeholder Baseline Readiness, Perspective and Buy-In (May 2006 Survey)” for the workgroup’s consideration as he moved through the results of this new survey. Dr. Foldy noted that the results in this document included more stakeholders than the version that was first presented to the eHealth Board in March 2006. One change that was noted between the first round of stakeholders and the expanded group was the movement of health care access to the most highly rated priority for health system improvement in Wisconsin. In the first round, the top response was increased evidence-based practice.

Dr. Foldy provided a briefing on the results from the prioritization exercise completed by the Patient Care and Consumer Interests workgroups. He reminded the group that they were each to complete the survey twice, first from a professional and then from a consumer standpoint, and was allowed seven votes each time to identify priorities.

a. Professional Survey

Respondents for the professional portion of the survey were charged with voting for the things that were most important in solving the most pain in the next five years; not what was practical or doable. A summary of the professional survey results follows:

- There were 14 respondents. 20 categories receiving two or more votes.
- By far the most prevalent priority was “Access across organizations” (9 votes).
- There was high emphasis on quality systems, including the need for shared information across organizations, care coordination and collaboration, patient record view and preferences, and public health surveillance and case management.

- Janice Hand asked where these sub-items came from in the scoring system. Dr. Foldy responded that the items in the list were roughly sorted into the following categories: safety (reduction of medical injury), administrative cost reduction, population health and health care access, patient empowerment, continuity and collaboration, research, redundant and expensive care, and quality systems. Based on the responses, the scores were combined and the general categories of high interest identified.

The workgroup discussed the definition of case management. It was noted that this was not clearly defined for those taking the survey and therefore the workgroup should be cautious about how this information is interpreted. Dr. Foldy noted that the workgroup had not discussed the difference between case management and disease management.

Dr. Barthell noted that increased evidence-based care was low on this prioritization survey, but high in the stakeholder baseline survey.

b. Results from Consumer Perspective

Having access to the medical information across organizations was again a clear leader in the results of the survey from a consumer perspective. Dr. Foldy said that there was clearly a strong focus on patient information tools, patient safety, and cost and efficiency. Quality and collaboration were high in both professional and consumer groups.

Dr. Foldy commented that the groups appear to be as interested in quality as in cost savings. This led to a discussion about the use of the term “value” versus “quality.”

Discussion

To begin the discussion Dr. Foldy noted that these results were not dissimilar from the results in Arizona and Michigan. Exchange of patient information across organizations is a top priority in the next five years.

The workgroup discussed what the prerequisites were for electronic health records. A summary of comments from meeting participants follows:

- Gary Bezucha said that access within organizations was necessary first, and then there would be information to share across medical organizations. Dr. Foldy asked if electronic medical records (EMR) were the way to get at this. Dr. Barthell suggested that information could be shared before organizations have full EMR capacity.
- Arthur Wendall reminded the group that it needed to define the building blocks, but also needed to clarify the ultimate goal.
- One member asked that quality be defined, because there are many different perspectives about what that is.
- Debbie Siegenthaler said that a needed prerequisite is identifying what information is to be shared, how to bring in future items over time, defining who will have access to these records, and who will administer those rights. She recommended looking toward groups in which electronic information is already being exchanged.

- Dana Richardson and Janice Hand echoed the sentiments on ensuring that confidentiality and security are considered.
- Dr. Barthell said he saw a need to identify the kinds of high-quality data already available and help facilitate ways to view this information across systems with the appropriate security in place. Ms. Siegenthaler commented on the need to recognize that these entities make their money based on these information systems. She thinks encouragement is needed for standardization among all these tools (legislated or through purchasing power).
- Kathi Steele commented that we may need to focus on both patient and provider needs in determining the information that is exchanged as the needs may be very different.
- Ms. Siegenthaler suggested a “face sheet,” which would identify commonly needed items for care, such as allergies, medications, etc.

To provide a different perspective, Dr. Foldy provided the following prerequisites to EMR identified in Michigan: 1) high-speed Internet access; 2) access to patient data on databases that already exist such as immunization; 3) need to identify source of data for quality; 4) displaying data that meets certain quality standards; 5) access to original clinical documents when possible; 6) exchange information in the same way (CCHIT certification); 7) authorization system, 7) record locator or master person index (MPI); 8) consent/opt out issues need to be defined; 9) confidentiality; 10) standardize what we can, but look forward to what can be standardized in the future.

The workgroup had a lengthy discussion about the first items that should be exchanged. The list of items identified includes:

- identity/demographics/master person index
- payers/insurance/coverage and eligibility
- diagnosis
- medications
- emergency contact
- immunizations
- allergies
- labs and other diagnostics (results reporting)
- discharge summaries
- advance directives

The workgroup agreed to evaluate this list, rank the items, and begin to address quality indicators for a future discussion. Staff will research how advance directives have been incorporated into other states’ plans for statewide data exchange.

4. Susan Wood drew the workgroup’s attention to the eHealth Board Workgroup Activities Diagram and asked the group to review this workflow diagram and provide comments. Alison Bergum noted that this diagram was not meant to record all interactions between the workgroups, but to identify key interactions. Dr. Westbrook asked how the group identifies content for this shared directory and asked that the language “Recommend content for information exchange” be added on the left side of the document.

5. Dr. Barthell asked for feedback on bringing these recommendations to stakeholders for broader validation. Ms. Wood suggested listening sessions or a written request for comments to some of the interested organizations. Ms. Siegenthaler suggested an overview document be created explaining the stage of the process the workgroup has reached. Dr. Barthell asked that an e-mail be circulated to the workgroup members asking them to identify the relevant organizations, outlining the background material to be provided, and asking for comments, suggestions, and contact information where necessary.
6. Dr. Barthell offered an opportunity to discuss the technical aspects of data exchange. There was some discussion about integrated data systems and information services that scoop information on demand.

Dr. Foldy offered Michigan's schema for the next five years. Michigan set a goal that all providers will have high-speed Internet (as defined today), all providers will have reasonable access to EMR, and a majority of people in the state are on the Internet and could use a secure system to access their data. Ms. Wood suggested that something along these lines be developed as a stakeholders background document to outline the assumptions made.

Dr. Barthell explained the agenda item regarding the development of use case scenarios. He explained that this was a next step for the workgroup. The scenarios are intended to be real-life examples. He suggested that the workgroup begin to look for examples that have already been created by other organizations. Dr. Barthell asked that as these are identified they be sent to any of the staff so they can be compiled for the full group at the next meeting.

7. Meeting schedule and communication between meetings
 - Next meeting is set for July 18, from 1:00 to 4:00 p.m. in Madison. Meeting location and conference call information will be announced later.